Prepared for

Office of Population
Bureau for Science and Technology
Agency for International Development
Washington, D.C. 20523
Under Contract No. DPE-3024-Z-00-7079-00
Project No. 936-3024

FIRST PHASE EVALUATION OF THE A.I.D. OPERATIONS RESEARCH PROGRAM (1984-PRESENT)

by

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Covering the period
January 1 - February 29, 1988

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Report No. 87-142-072
Published May 4, 1988

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ACKNOWLEDGMENTS

I would like to acknowledge the help and cooperation I received from all the staff of the Operations Research (OR) program and especially from the OR coordinator, Dr. Jerald Bailey, Deputy Chief, Research Division, S&T/POP. The people interviewed also generously gave of their time and attention because of their interest in the OR program.

NOTES

Definitions: The OR "program" refers to the totality of 15 years of OR activities supported by A.I.D. The OR "project" refers to the work under the current project paper (1984-1988). OR "subprojects" refer to the OR studies in the field.

The references appearing in the text in parentheses can be found in Appendix B.

GLOSSARY

CTO	Cognizant Technical Officer
CA	Cooperating Agency
CBD	Community Based Distribution
IEC	Information, education and communication
LDC	Less developed country
OR	Operations research
S&T/POP/R	Bureau for Science and Technology/Office of Population/Research Division
TA	Technical assistance
URC	University Research Corporation

EXECUTIVE SUMMARY

This first phase evaluation of the A.I.D. Operations Research (OR) Program sought to "examine, describe, and assess the first three years of the OR program under the current project paper," to compare the program during these three years (1984-1988) with the previous OR program (1973-1984), and to make recommendations for future OR activities of A.I.D. The report was to include an agenda for a more thorough second phase evaluation.

Since this was only the first phase evaluation and it had to be completed quickly, the information was collected through interviews with key people knowledgeable about the OR program and by reviewing documents pertaining to the program rather than by visiting field offices or subproject sites. Interviews conducted with people outside the A.I.D. office were done by telephone and in person at the Annual Meeting of the Office of Population's Cooperating Agencies (Jan. 19-21, 1988). Nineteen of the fifty persons interviewed reside in developing countries which are sites of OR subprojects.

The objective of the OR program has remained constant over the past 15 years: to provide technical assistance and financial support to developing country family planning programs to improve their service delivery through carefully designed and executed subprojects that diagnose existing service delivery problems; to try new approaches to service delivery, and to collect and make available information useful for improving service delivery.

When the OR program began, it emphasized subprojects involving household and community based (non-clinical) distribution of pills and condoms (and less often, spermicides) in rural areas. Studies often used quasi-experimental designs and baseline along with endline surveys. The main output of interest was usually contraceptive prevalence. The philosophy was that the best way of learning how to improve service delivery was to try different delivery approaches and carefully evaluate the results ("learn by doing").

Although about a third of the more recent projects follow this model, there have been marked changes in the types of subprojects initiated during the two time periods. Previous subprojects (1973-1984) were more likely to involve household distribution of contraceptives, free services and family planning services. Current subprojects (1984-1988) are more likely to be clinic based, feature paid services or purchased commodities, to be set in urban areas, to emphasize referrals and IEC approaches, and to promote male methods and IUDs. Output measures increasingly focus on cost-effectiveness, self-sufficiency, and

efficiency rather than (or in addition to) contraceptive prevalence.

Although quasi-experimental designs still predominate, more of the recent studies have no control group and could be considered diagnostic studies. Data collection approaches now used most frequently include service statistics, service provider interviews, administrative/cost records, patient/client interviews and qualitative approaches.

Among those interviewed in this first phase evaluation, there was unanimous support for continuing A.I.D.'s OR program. The designs and topics may change but the need for improving the quality of services and their cost effectiveness remains. To a considerable extent, the OR program has become localized and is now meeting country and project level needs for improving family planning service delivery. The technical contributions of the OR staff in Washington were mentioned in many interviews.

Critical comments emerging from interviews included the following: 1) Some respondents felt that the institution building component is not given sufficient acknowledgment or attention in Washington. 2) Although the program has been changing and some of those interviewed felt it was a flexible program, others felt it was still too rigid and that this sometimes caused difficulties for field staff who were trying to adapt subprojects to local conditions and needs. 3) Some people felt that the OR program lacks visibility outside the OR "family" (i.e., those getting funded to do OR projects) and seems to separate itself from other A.I.D.-supported family planning evaluation activities. 4) Some people felt that the OR staff in Washington sometimes "micromanage" subprojects and occasionally add to delays in getting subprojects going. 5) Some felt that the program overemphasizes numbers of subprojects initiated and their impact on contraceptive prevalence at the expense of technical assistance and more general products including those that cut across regions.

Interviews with the OR staff made it clear that the OR staff are aware of these issues and have been working on them. Perhaps people in the field are not aware of this and there is a communication gap between Washington and the field on some of these issues.

Evaluating the performance of OR contractors was <u>not</u> part of this first phase evaluation. It should be noted, however, that some respondents felt there was room for improvement in both the quality and quantity of work done by some OR staff in the field.

Major recommendations were: 1) The OR program should be extended for five years (1989-1994) and with its current regional

organization; 2) The program should continue on its course of increased flexibility in research topics, designs, and administrative arrangements; 3) The OR staff in Washington should focus less on details of research design and more on establishing general standards for the quality of the research and on disseminating information about the program within and outside A.I.D.; 4) Ways should be developed to quantify and acknowledge the importance of technical assistance in the OR program; and 5) More effort should be made to share information and expertise between the OR program and the many Cooperating Agencies supported by the Office of Population involved in family planning evaluation in developing countries.

I. INTRODUCTION

I.1 Scope of Work

The purpose of this assignment was to "examine, describe and assess the first three years of the Operations Research (OR) program under the current project paper." (1) A companion objective was to produce a detailed evaluation agenda to guide the more comprehensive second phase evaluation scheduled to take place in the coming year. This phase one evaluation was expected to generate ideas for improving the OR program by reviewing documents produced by the program and by interviewing knowledgeable individuals directly or indirectly involved in the OR program. The focus was on the worldwide program rather than on the regional programs.

A.I.D. has a long history of supporting programmatic research to improve family planning programs. Some of this research comes under the OR program; other research has been done as part of contracts for service delivery, technical assistance (TA), and clinical trials. This report is limited to the programmatic research funded by the OR program.

This assignment, conducted through a part-time consultancy, was to be completed in about a month and involved one person, working in Washington, D.C. and North Carolina. The main sources of information were documents (Appendix B) and 50 interviews with OR staff from the Bureau for Science and Technology, Office of Population, Research Division (S&T/POP/R), Bureau staff, USAIDs, Population Officers based in selected USAID Missions, university researchers, project directors and staff of the current OR contractors, and knowledgeable individuals in other population/family planning organizations (Appendix A).

The first interviews took place at the time of the Annual Meeting of the Office of Population's Cooperating Agencies (CA) January 19-21, 1988 to take advantage of the attendance of OR project directors and several of their staff. To facilitate interviews with those in the field, Population Officers were informed of the interview by an A.I.D. cable. Those interviewed in Washington were given a copy of the scope of work if they requested it.

Interviewing Population Officers by phone worked quite well although it took several weeks to track some of them down. It was not possible to contact Population Officers in Ghana and Zaire. Several telephone interviews were a bit rushed and did not cover all the questions. This was occasionally a problem in face-to-face interviews as well, since the respondents were very busy people. Detailed notes were taken during the interviews. Illustrative questions appear in Appendix C. The number of questions was reduced for international calls.

I.2 Limitations

There were several limitations in this phase one evaluation. It was conducted over a short time period and there was not time to contact everyone who would have had useful things to say about the program and how it might be improved. Nor was it possible to read all the potentially relevant documents, although a substantial number were reviewed (Appendix B).

The author of this report had not previously been funded by the OR program and had not been intimately involved with it. Thus, much of the material on its history and current projects was new, and it took some time just to become familiar with the organization of the program. On the plus side, this meant that the author had few preconceived notions about the performance of the program to date.

Some of the current OR contractors were initially suspicious of participating in an evaluation conducted by someone from another CA. This concern usually diminished when it was made clear that this was not an evaluation of the regional programs or subprojects. The problem was also counteracted to some extent by interviewing more than one representative of each current project (except for the Zaire OR program where only the director was interviewed).

II. OBJECTIVES AND FOCUS OF THE OPERATIONS RESEARCH PROGRAM

II.1 Objectives

II.1.1 Background

As noted in the scope of work for this evaluation:

> "A.I.D.'s OR program began in 1973 as part of an effort to move away from a reliance on clinic based family planning service delivery. Much of the early OR effort was to initiate community based distribution (CBD) programs and to measure their impact on contraceptive prevalence rates. The program grew and 10 years later six S&T/POP professionals were managing a budget of about $6 million with eight Cooperating Agencies and had greatly expanded the focus from CBD programs to include nearly all facets of family planning service delivery."(1)

Many of the early projects were initiated by staff from the Office of Population and were administered through a variety of organizations. In 1984, A.I.D. approved a new 10-year family planning operations research program, "Strategies for Improving Service Delivery," with funds approved for five years (5/1/84 to 4/15/88). Since 1984, the projects have been managed by five organizations: The Population Council for Latin America and the Caribbean; Columbia University for Africa (plus activities in Haiti and Indonesia); Tulane University for Zaire; the University Research Corporation (URC) for Asia; and Johns Hopkins University for four projects in Kenya. There have been several additional OR projects handled under other mechanisms such as projects of The Population Council in Bangladesh, Zimbabwe, and Zaire. Four staff of S&T/POP/R monitor these contracts and Cooperative Agreements.

II.1.2 General Statement of Objectives

The objectives of the OR program have remained remarkably constant over this 15-year period, and there is general agreement among those interviewed that these objectives are worthwhile: namely, to help initiate family planning services where these services do not exist and to improve services (accessibility, utilization, efficiency, impact, and acceptability) where they do exist.

As described in the Project Paper for the current OR Program (1984-present), the general goal is seen as two-pronged: 1) "to improve the acceptability, accessibility and cost-effectiveness of FP/MCH [family planning/maternal and child

health] service delivery systems and 2) to develop LDC [less developed country] institutional capabilities to design and carry out operations research so that they can use this tool more broadly for the improved design and management of programs."

Most recently (1987), priority areas of the OR program were enumerated by the OR Program Coordinator as follows: "1) expanding peoples' access to family planning services and supplies; 2) improving the operations of programs by making them more efficient; 3) increasing the use of underutilized contraceptive methods; and 4) providing more acceptable services to special population groups."(2) This list was arrived at deductively from an examination of the types of subprojects actually under way, not superimposed by A.I.D./Washington.

II.1.3 Issues

Although it is generally agreed that both goals set forth in the Project Paper are valid, there is some discussion as to the priority that should be accorded to each. The Project Paper indicates that TA should be applied to facilitate the achievement of both goals. In Washington (i.e., staff within the Office of Population), however, TA is seen primarily as a means to getting projects started and completed. Those in the field, on the other hand, see TA as playing a more general role, namely to build up organizations so that they can carry out their own OR projects to improve service delivery. In the former view, TA is necessary to identify potential subprojects, draft proposals, help organizations implement them, and assist in documenting and disseminating results. In the latter view, an important goal of TA should be to make local organizations independent and able to conduct OR without outside assistance or funding. Several respondents stressed that LDC family planning organizations could easily do this: They very often have data available that could answer important questions for very little cost, but they do not take advantage of the situation, partly because they do not know what can be done.

This need for TA was stressed both for countries with more developed family planning programs where the need is to "do more--with less" [resources] and make better use of data being produced by the program rather than undertaking special surveys and studies. It was also stressed for countries with fledgling family planning programs and limited research experience.

In short, the field tends to perceive that A.I.D./Washington lacks interest in the institution building component. Many of those interviewed, especially those in the field, emphasized that a major objective of the program should be to build the capability of local program managers and policy makers to benefit from OR research and to build local

capabilities to conduct (and disseminate) appropriate OR studies.

Washington and the field in fact may not be very far apart in their views, but Washington's commitment to TA may not be conveyed to the field as often as its interest in research design. Most communication between the OR staff in Washington and the field deals with research design issues or administrative, personnel, or financial matters with very little reference to TA, which may be taken for granted on both sides. In practice, a good deal of effort by OR staff is going into building local capability.

Recommendation

TA for institution building should be considered an integral part of the OR mandate. This means that time and funds should be made available, including within the OR projects themselves, for TA, and ways found to measure its quantity and quality.

II.2 Focus

II.2.1 Traditional View

Although respondents generally agreed that OR should be used to improve family planning services, there was less agreement on the means. In fact, respondents expressed quite different views on what the term "Operations Research" includes or excludes. In many settings, the projects have attempted to "show it can be done: that is, that services can be expanded and that people will use them. The orientation has been to "learn by doing," and the term "Operations Research" is sometimes used interchangeably in project documents with the term "action research."

The OR Project Coordinator is one who uses the terms interchangeably. He has described the OR program in the following terms:

> "In general an action research project begins with a service delivery problem, changes some aspects of how family planning is being provided, and based on scientifically gathered, empirical data determines if the modification increases contraceptive use and/or is a more efficient use of program resources." (2)

In short, the means here is to show or demonstrate that services can be used on the assumption that contraceptive prevalence will rise accordingly. Consequently, the program has tended to favor subprojects with service delivery interventions

(demonstration projects and quasi-experimental designs) over diagnostic studies or evaluations of ongoing programs. In fact under the first OR program, nearly 70 percent of all projects were either demonstration or quasi-experimental designs (see Table 2).

One argument in favor of supporting mainly intervention projects is that the willingness of a family planning manager to try an alternative service delivery approach often indicates a commitment to improving services that deserves encouragement. This contrasts with some organizations that just want to do diagnostics or evaluations without any commitment to change or improvements.

In general, A.I.D. staff remain highly committed to the original notion that the OR program should involve action research that shows that "it can be done" (i.e., that family planning services can be delivered in a cost efficient manner and that family planning use can be increased, even in the most unpromising of settings), a case convincingly argued in a 1984 paper by Mamlouk and Gillespie. (6)

II.2.2 Alternative Approaches

On the other side, it is argued that "showing it can be done" may not the most effective way to accomplish the OR program's objectives. For example, in settings with fledgling family planning programs, the highest priority may be to put the service statistics system on a sound footing rather than to show that services can be delivered effectively. For instance, if an accurate service statistics system were to be established, it could be used to monitor action research programs. Family planning programs need basic information on characteristics of acceptors, continuation, effectiveness, costs, knowledge of providers, and the like. According to the more field-oriented respondents (particularly Population Officers and Bureau staff), the criterion for supporting a project should be an assessment of its chances of improving family planning services, rather than its design per se.

Another argument for moving away from programs that "show it can be done" is that this approach has become outdated. The point is made that family planning programs in many areas of the world have already proven that there is a demand for family planning, that family planning services can be delivered without undue controversy, and that they can contribute to the decline of fertility.

The case for a more eclectic approach was expressed by many of those interviewed outside the Agency. These respondents favored spending a good amount of time in identifying an

important problem and then selecting the research approach that would best contribute to the solution of that problem, whether or not this implied action research.

II.2.3 Conclusions

With respect to the issue of whether intervention studies are more likely to lead to change because they reflect commitment on the part of the family planning manager, the conclusion is unclear. Just as some intervention projects may not lead to changes, some diagnostic studies, field studies, or other approaches may lead to improvements. It is not easy to predict which field projects will have beneficial outcomes since this depends to a great extent on political and personality considerations. In short, an intervention study may or may not be useful. It depends on whether the intervention is appropriate, practical, and replicable. Similarly, a non-intervention study may or may not lead to improvements of a program.

With respect to the issue of whether there remains a need to "show it can be done," the case can be argued both ways. Certainly, in some settings (Pakistan, a number of African countries, Bolivia, Haiti), what is still needed is evidence that "it can be done." In these settings, the OR program could make a very important contribution using its classical approach.

On the other hand, particularly with AIDS having propelled family planning programs into the "age of the condom," the need may be to turn to the long (and not so glamorous) task of improving access to family planning in the least expensive ways. Outside of a few countries where family planning has not become established, there may not be further need for complex, expensive, and superscientific experiments to prove it can be done.

Does this mean the OR program may lose its identity and become just another family planning evaluation effort? To some extent, there may be advantages to losing a little of its identity as a program that sponsors special studies and experiments (sometimes outside the mainstream family planning programs). In any case, the OR program is already changing in this direction. It is departing from its origins (CBD, household distribution, non-clinical methods) and moving towards approaches that test cost effectiveness, cost recovery, and urban settings (see Table 2).

To summarize, the controversy can be reduced to the issue of flexibility, with some of those interviewed feeling that the OR program is flexible and others maintaining that, although changes are being made, the program is still too rigid and that

this scmetimes has caused difficulties for field staff who were trying to adapt subprojects to local conditions and needs.

The consensus among those interviewed, however, was that the hallmark of the OR program should be FLEXIBILITY (a term that came up in almost every interview and usually more than once). The opinion, especially of field people, was that they should be able to carry out programs that fit local needs, regardless of the research design to be used.

In short, the recent definition given by Ross et al. (7) is probably as good as any for OR: "...operations research is the application of research methods to improve action programs." (p.128) The authors go on to state, "Operations research need not be long-term, sophisticated or academically oriented. Instead, it should be an effective way to find corrective measures, identify viable alternatives and discover useful innovations." (p. 135)

Recommendations

1) OR should be defined more by its goals than its research methods.

2) Some assessment must be made of the chance that improvements will result in family planning services from OR studies, before, during, and after the project. The research design is only one of many factors that will determine whether improvements will result.

3) There is no need to change the objectives of the program. Rather the need is to increase flexibility (responsiveness to local needs, delegation to the field, innovation, and dissemination of results) rather than to be wedded to the testing of non-clinical models of service delivery.

III. NATURE OF THE SUBPROJECTS

This section focuses primarily on a comparison of the types of subprojects in the previous and current OR projects (1973-84 vs. 1984-present).

In Table 1 comparisons are made with respect to country and regional distribution and in Table 2, with respect to topics addressed. The section concludes with a comparison of the types of subprojects by region of the world, as shown in Table 3. (The tables can be found at the end of the report.)

III.1 Geographic Distribution

With respect to geographic distribution, both OR projects had concentrations of subprojects in Colombia. In addition, the previous project had a concentration of subprojects in the Philippines whereas the current project has multiple subprojects in Peru and Zaire. Subprojects tend to be concentrated in countries with a field or regional office, since it is more convenient to have subprojects within easy access of the regional office. The Near East is not included in the current program, and thus the number of subprojects there has declined there from 8 to 0.

III.2 Pace of Implementation

Overall, the pace of subproject development has increased in the current program: More studies were initiated in the past four years (N=87) than were in the previous 11 (N=78).

III.3 Characteristics

The characteristics of the subprojects in the two projects are analyzed on the basis of information from the A.I.D. Population Projects Database. Some interesting trends are evident from a perusal of Table 2. Most reflect the new A.I.D./Washington Office of Population trends, namely concerns with cost and with integrating research into service delivery rather than emphasizing special-purpose survey data collection.

Regarding the type of family planning service being evaluated (Panel A), newer projects are more likely to focus on clinic services and less likely to involve household distribution points. Another striking change is that fewer of the programs being evaluated offer the methods free. The explanation is that given funding constraints, cost recovery is now an important issue. Consistent with this emphasis on cost recovery is an increase, albeit it less dramatic, for projects to involve social marketing.

Another change is for referral to be a characteristic of somewhat more projects. The explanation for this is less clear, although it is consistent with the focus on clinic services and clinical methods, especially the IUD (see discussion on Panel B). A final change is that projects are more likely to be in urban areas. In some countries like Indonesia, this may reflect the lack of development of urban family planning programs, particularly in slum areas, in comparison with rural family planning programs. In other settings, it may reflect the concern for cost recovery, which may be easier to initiate in urban areas.

Panel B shows changes in methods offered by the family planning programs being studied. The most noticeable change is that IUDs, usually a clinical method although they have occasionally been delivered in the home, are more likely to be a part of the family planning programs doing OR studies. Male methods (condoms and vasectomy) also show an increase. Pills, female sterilization, and natural family planning, are less likely to be offered in the programs being studied, although pills are still offered in the majority of programs. Only one subproject involves NORPLANT^{R}.

Panel C indicates that new subprojects are less likely to involve other health products than were the previous subprojects. This may reflect the finding of some OR studies that provision of other health services may not contribute to increasing family planning use (5), plus the unavailability of funds from the A.I.D. Office of Health to fund this joint work.

Panel D shows that there have been some changes in the research issues being studied. The cluster of issues that includes CBD, distributors, promoters, primary health care services, supervision, and training is now the focus of a lower percentage of studies whereas studies that look at clinic services, information, education and communication (IEC), IUDs, and vasectomies are increasing. The inclusion of AIDS prevention programs is not reflected in the statistics because this is not yet a category under "research issues."

Research designs have not changed dramatically (Panel E) except for a decrease in demonstration projects. Studies with quasi-experimental designs are still the most common (37-42 percent) with a slight increase over time.

The changes in data collection approaches (Panel F) are quite dramatic. There is a sharp increase in the use of service statistics, interviews with providers and clients, and increasing use of administrative data including cost data. Repeated surveys and censuses have had a concomitant decline.

This indicates a scaling back of special-purpose OR surveys. Instead, subprojects are using routinely collected data. There is evidence of a new concern with programmatic research using service statistics, a focus on clinic services and underutilized methods (especially the IUD) and an increased concern for costs. Although not all recent subprojects are in this mold, this is the trend between the two time periods.

III.4 Characteristics by Region

With respect to types of projects in different geographic regions, Table 3 shows very clear differences. Compared with the average, the subprojects in Africa are more likely to be CBD projects with distributors; more likely to be demonstration projects; more likely to be measuring continuation rates or prevalence and less likely to be studying cost-effectiveness. Although the majority of the subprojects in Africa as elsewhere have an urban focus, there are relatively more rural projects in Africa. In the African subprojects, sterilization and IUDs are less likely to be part of the project while spermicides are more likely to be part.

The subprojects in Asia are more likely than the average for all subprojects to involve CBD programs or involve clinic services and less likely to involve distributors. They are more likely to deal with self-sufficiency. In design, they are less likely to be demonstration projects and more likely to be evaluations or diagnostic studies. Monitoring in the Asian subprojects more often involves active users, new acceptors, and efficiency. The family planning service delivery programs are more likely to be clinic-based or involve household distribution posts. Methods are more often free and referrals are more often a component of the OR subproject. Methods like sterilization, injectables, and IUDs are more likely than the average to be included and spermicides, less likely.

Since almost half of the subprojects are in Latin America/Caribbean, they contribute heavily to the overall average and therefore, tend to have a distribution similar to the total. Nevertheless, the Latin America/Caribbean subprojects are more likely to involve IEC and training. They are more likely to focus on cost-effectiveness. In the family planning programs being evaluated, methods are more likely to be sold (including in social marketing programs) and subprojects are more often in urban areas.

The configuration of subprojects by region reflects the differing levels of development of family planning programs (for example, there is more need for demonstration projects in Africa than Asia); differential opportunities; and the interests and backgrounds of the OR field staff.

IV. GENERAL PRODUCTS AND DISSEMINATION

IV.1 Introduction

Although a considerable number of excellent general products have been produced by the OR program (or are under production), there is a general perception that sufficient attention has not been given to dissemination of findings. Some of those interviewed expressed the view that the OR program lacks visibility outside the OR "family" (i.e. those being funded to carry out OR projects). There was also the impression that the OR program seems to separate itself from other A.I.D.-supported family planning evaluation activities. This comment reflected particularly the situation with respect to a number of organizations that are incorporating evaluation components into their subprojects (e.g. The Pathfinder Fund, the Association for Voluntary Surgical Contraception, John Snow, IPPF, FPIA, John Short, Family Health International, and INTRAH). The OR program does not seem to be making an effort to share its experience and expertise with these organizations. Better communication might facilitate the work of the CAs, and perhaps also the results of the studies would be more valuable. Finally, the view was expressed that the OR program lacks definition, that it has not projected a clear image of its purposes and its focus.

IV.2 Products

The project has done a good job in documenting the results of its efforts to introduce and improve services.

Following is a list of the principal products.

1. Books: At least three books have been published on OR findings and with the support of the program (see Appendix B, "Books").

2. The OR manual, which has proven to be very useful for teaching and workshops, was produced by The Population Council and has now been translated into a number of languages including Spanish, French, Bahasa Indonesia, and Thai. An Arabic version is under preparation by the National Population Council.

3. The Population Report on OR was prepared with extensive assistance from the OR staff of A.I.D.

4. The Latin American regional project is producing an OR newsletter (in Spanish and English), which it distributes to 1,500 readers every six months.

5. Videotapes are being produced on how program managers can use OR and on how program managers can learn from focus groups.

6. Papers have been presented at professional meetings on A.I.D.'s OR program (see items 2 and 4 in Appendix B).

7. Two to three hundred papers have been published, based on work supported by the OR program.

The only concerns with respect to products being produced were brought up at the Cooperating Agency meeting and focused on a need for products that go across regions--i.e., state-of-the-art papers on topics like sustainability, use of service statistics, family planning management, research instruments, manuals and videotapes.

IV.3 Dissemination

The OR program has much to commend it both in its specific subprojects, the TA it has provided, and the general products it has produced. That more effective efforts have not been made to disseminate information on the results of these efforts appears to be a disservice to the program as a whole. Specific shortcomings expressed by respondents included lack of money within individual subproject budgets for dissemination of results; too little effort to disseminate widely news of new subprojects at their inception, rather than at their termination; too little dissemination of subproject failures, which many felt would be more instructive than the stories of success; and too little sharing of experiences between regions.

Considerable work remains to be done to disseminate the results of the 82 subprojects currently ongoing. If some of the suggestions provided in Appendix D on dissemination were to be incorporated into this effort, perhaps the OR program might counteract the criticisms that it lacks definition and visibility.

Recommendation

A.I.D./Washington should give more attention to information dissemination in the next few years. What is needed is to make the program more visible within A.I.D., the Bureaus, and the Missions; to share information on OR with non-OR CAs; to synthesize the OR experience; to share experience cross-regionally; and to commission more general products. In short, the program needs more "selling" within and outside the Agency, a task that will take time and attention.

V. MANAGEMENT ISSUES: ROLE OF S&T/POP/R

V.1 Summary

Although the focus of this evaluation was not on S&T/POP/R, many of the comments made during interviews, particularly those from field staff, reflected on the management style and management choices being made in A.I.D./Washington.

Some of the differences between the field and Washington have been explored in preceding chapters: specifically, the sense that Washington lacks interest in using TA for institution building, a perceived lack of flexibility, and the perception that more aggressive action could be taken to analyze and disseminate OR findings and thereby project a clearer image of the OR program, its goals and accomplishments (see Chapters II and IV).

The issues to be discussed in this chapter relate to two other perceptions: 1) that Washington tends to "micromanage" projects, and 2) that the program overemphasizes numbers of subprojects initiated and their impact on contraceptive use, in preference to providing TA and more general products that cut across regions.

Interviews with the OR staff made it clear that they are aware of all the issues raised here and earlier and have been working on them. Apparently, people in the field are not always aware of this. That a communication gap exists between Washington and the field should serve to soften some of the critical comments. Nonetheless, the issues raised by the field contain enough substance to merit further discussion.

V.2 Micromanagement

With respect to micromanagement, some people observed the OR staff in Washington sometimes "micromanage" subprojects and occasionally add to subproject delays. It is true that OR staff in Washington spend considerable time in reviewing the research design of individual projects, rather than establishing general standards for quality of research. The role of the Research Review Committee is particularly questionable. Each proposed OR project must be approved by the Committee, rather than by the Cognizant Technical Officer (CTO).

There are several compelling reasons why S&T/POP/R staff should not concentrate solely on subproject management. The first is very practical: i.e., lack of means to supervise project activities. Specifically, S&T/POP/R staff are restricted in their ability to travel. This puts a severe limitation on the

extent to which they can play a close advisory role in subprojects. This is clearly a drawback: An inability to visit projects regularly is detrimental to the monitoring function. Moreover, the overall trend in A.I.D. seems to be for fewer staff to monitor more projects and money (including more administratively taxing buy-ins). If this trend continues, the recommendation of more delegation to contractors may come about by default.

A second reason why S&T/POP/R should relinquish some of their involvement in subproject management is that their participation may complicate and slow the approval process. The work is quite complex and it may take months or years to complete subproject preparation. The OR contractors already have at least three organizations to which they are responsible: their own organizations, the local Missions (some of which are putting their own money into OR studies), and the local organization and/or host government. A fourth organization that is far away can complicate things a great deal. As was pointed out in many of the interviews, those in the field are in a much better position than those in Washington to know what will be useful and practical.

Third, it may not be necessary to use S&T/POP/R expertise, as research expertise can generally be purchased from outside the Agency. Finally, too great an involvement in subproject oversight may be deflecting OR/Washington staff from activities that should have higher priority, particularly with respect to synthesizing the large body of OR experiences over the past 15 years and disseminating the results (see Chapter IV).

V.3 Overemphasis on Numbers of Projects and Contraceptive Prevalence

With respect to the second issue, that the program overemphasizes numbers of subprojects and their impact on contraceptive use, it is true that the pace of subproject implementation has accelerated in recent years (see Section III.2).

It is also true that the issue of evaluation of subproject impact has not been dealt with effectively. When nearly 50 respondents were asked to identify subprojects that had clear policy relevance and impact, two dozen subprojects were identified as having led to improvements in family planning programs. In some cases, the impacts cited were a bit vague, however, (e.g., "improved the climate for IUDs in the Sudan"). In this case, it would have been more impressive to have demonstrated an increase in IUD use in the Sudan or at least an increase in the availability of the method. On the other hand, making determination of impact is not easy and might need to

involve launching of follow-up efforts to assess more precisely the impact of completed projects and factors contributing to that impact (or lack of impact).

The field has also expressed the view that projects should be evaluated in part by how much TA they provide. This has occurred in one instance when the OR program evaluated one regional program in part on the basis of the TA provided. Here, evaluation criteria included both number of days of TA and project development/TA trips in addition to the more conventional criteria of numbers of people trained/number of workshops, concept proposals, numbers of projects started and completed during the specified time period, and numbers of citations in Popline. One reason for including TA may have been that the project had no completed subprojects and that therefore it was not possible to measure changes in contraceptive prevalence.

V.4 Technical Assistance

With respect to the comment that S&T/POP/R staff should put more emphasis on providing TA, there is no question that this is where A.I.D./W staff themselves would like to be making additional efforts. Due to lack of funds, however, they are constrained from doing more in this area (see Section V.2). They have been given high marks, however, for the TA they have been able to provide. Many of those interviewed mentioned that the OR staff in Washington had provided valuable TA to the worldwide and regional projects. This was particularly true when a region had few resources (Caribbean), when a new project was having start-up problems (URC), or when the Washington staff had extensive research experience in the region.

A related issue is whether TA should continue to be provided as part of the existing OR Cooperative Agreement or whether an additional Cooperative Agreement should be developed that would also be a source of TA. Several respondents were strongly of the opinion that the existing arrangement was appropriate and that a separate agreement was not needed.

To summarize, the prevailing view was that now, after 15 years of experience, A.I.D. and its contractors should move to a new mode of operation that capitalizes on their accumulated knowledge and expertise.

Recommendations

1. The job of the S&T/POP OR staff should be to make sure that the objectives of the program are clearly understood by project directors and staff and that all projects should directly contribute to the objectives. The role of the Washington OR

staff should be to provide general guidelines and standards, not detailed review of research designs.

2. OR staff in Washington should concentrate on making general contributions to the family planning evaluation field. They should spend more time on synthesizing the very large body of OR experiences that have accumulated over the past 15 years, disseminating findings of projects, defining general products and making sure they are produced, attempting to integrate OR activities into all population activities, and working with non-OR CAs to improve evaluation activities.

3. The Research Review Committee should assume less significance. Its prime focus should be on review of research results and their implications for policy and information dissemination, with secondary emphasis on research design. Each CTO should be primarily responsible for approval of subprojects.

4. The CTOs should have more autonomy to approve projects promptly without extensive review by the Research Review Committee. Of course, this does not preclude informal consultations with others (including in the Bureaus) when appropriate.

VI. REGIONAL ORGANIZATION

The regional organization of the OR program was generally accepted as a fait accompli. The only concerns were bought up at the CA meeting: the need for sharing experiences and products across different regions (see Chapter IV) and the problems of competition between the projects due to the bidding process. These concerns do not carry great weight when set against the prevailing view that it is important to increase the ability of local organizations to carry out OR. Moreover, means other than developing a worldwide project can be found to foster inter-regional communication.

With one exception, the closer a Population Officer was physically located to a regional or field OR office, the more positive he or she tended to be with respect to the OR program. Examples of this phenomenon were Population Officers in Peru, Mexico, Cote d'Ivoire, and Indonesia. Given the practical and programmatic nature of good OR, having a local office makes it likely that OR staff will be able to respond on a continuing basis to local program needs (as well as Mission needs). A resident advisor has a better opportunity to help local staff make do with what they have (i.e., use service statistics) than someone who comes for a short visit. Resident advisors and regional/field offices are expensive, however, especially if the organization setting up the office insists on having elaborate facilities.

Recommendations

1. The current regional organization of the OR program should continue.

2. Regional offices and field offices should be an important part of the OR program, but every effort should be made to keep down costs by judicious location of the offices, employment of local staff who do not need to relocate long distances, and by efforts to keep facilities modest in scale. If an advisor were attached to a family planning evaluation unit, for example, he or she might not need to set up a separate office.

3. As the new subprojects begin to produce results, more thought should be given, especially by A.I.D./W staff, to cross-regional products that can be produced by the OR program (see Chapter IV).

4. Representatives of each project should be encouraged to attend conferences held by other projects and to present results that might be of interest to the host region. Both project

directors and other staff members, including local staff, should participate.

VII. MAJOR CONCLUSIONS AND RECOMMENDATIONS

VII.1 Conclusions

In the 50 interviews, only one person expressed some lack of enthusiasm for continuation of the OR program and that referred to only one region (the Caribbean). All of the others felt the program was worthwhile, although many felt that improvements should be made.

Clearly, the program is providing an opportunity for family planning programs in selected developing countries to try new approaches to service delivery before introducing changes on a large scale. It is also adapting to the changing issues in family planning programs (for example, cost issues).

Almost all of those interviewed felt that OR was important and should be a part of A.I.D.'s portfolio of projects. Most of the Population Officers who had close contact with current OR programs were pleased with the work being done. In short, the OR project has been productive, both in the numbers of subprojects and in more general products.

VII.2 Recommendations[1]

1. The OR program should be renewed for another five years (1989-94).

2. The program should become more flexible and responsive to field conditions. This could involve giving contractors more autonomy, being more eclectic in the kinds and designs of projects, and shortening the project review period.

3. More attention should be given to increasing the visibility of program results and to packaging and selling the products beyond the "OR family."

4. Opportunities should be seized to interject OR approaches and findings into the planning (and training) process at the Agency itself. For example, when individuals are being trained to take field positions, they could be oriented about OR in general and in the specifics related to their country of destination. There is also a need to go beyond A.I.D. to other CAs and population organizations. Video tapes of how to use OR to improve services could be incorporated into management

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[1]These recommendations are based primarily on suggestions made in the course of the interviews conducted during the assignment (see Appendix D).

training courses (such as CEDPA's). Project staff are probably in the best position to identify opportunities.

5. Less time should be spent on micromanaging subprojects. This would put more of the design responsibility on the contractors, raising the issue of how A.I.D. can promote better performance of contractors without doing the work for them.

6. Much more emphasis should be given to evaluating the effects, if any, the subprojects have on family planning programs. In order to do a more profound evaluation of the impact of subprojects after some time has elapsed, follow-up site visits (and possibly some empirical evaluation) could be very informative in identifying which kinds of projects have a long-term impact and which ones do not.

VIII. PROPOSED AGENDA FOR SECOND PHASE EVALUATION

A second phase evaluation should involve team visits to some of the projects and subprojects and review of all subproject proposals, final reports, and published papers. In order to save time, advance preparations should be made. For example, multiple copies of all the relevant documents should be collected including copies of any previous evaluations. The evaluation should include in-depth coverage of the performance of the regional projects and a full analysis of issues.

The issues that might be reviewed include the following:

1. What is the proper role of the A.I.D./W staff? What should be their focus? Where should they reduce their efforts? Should CTOs have projects that they monitor directly (i.e. that do not go through a CA)? This might make the job more rewarding, but the problem of insufficient travel money and staff time would need to be resolved.

2. How might the OR program achieve more visibility and how it might have more influence on policies relating to family planning services within A.I.D., the research and academic communities, other CAs, and within family planning programs in developing countries?

3. Should the emphasis on topic areas continue to change? What should the emphasis be over the next five years? Appendix D contains many valuable suggestions for research topics and designs as well as suggestions regarding administration and utilization of findings.

4. What can be learned about the long-term impact of various types of subprojects? This analysis will require site visits and possibly additional field work. Do large projects have proportionately more impact than small ones? Should projects be concentrated in certain countries or within one organization to have the maximum benefit?

5. How can research dissemination and utilization of findings be improved?

6. What role should American universities play in family planning OR? Currently, the only role for universities is to train new researchers. For their professional development both faculty and students could profit from involvement in field projects. They could also provide TA and methodological sophistication to OR projects. The current system of administering OR through large CAs, however, may cut out universities. Could the RFPs be written so that there are

opportunities for universities to participate?

7. What general products can be gleaned from the OR program, now that it has been in existence for 15 years? A few suggestions appear in Appendix D.

TABLES

Table 1. Distribution of Sub-Projects
by Region and Country

	1973-1984	1984-1988
ASIA		
Bangladesh	4	6
Indonesia	-	8
Korea	2	-
Nepal	-	2
Pakistan	-	1
Philippines	7	-
Sri Lanka	3	2
Taiwan	1	-
Thailand	7	5
Regional Asia	1	-
Subtotal	25	24
NEAR EAST		
Egypt	4	-
Morocco	2	-
Tunisia	2	-
Subtotal	8	0
AFRICA		
Burkina Faso	-	1
Gambia	-	1
Ghana	-	2
Ivory Coast	-	1
Kenya	4	-
Liberia	1	-
Mauritius	1	-
Niger	-	1
Nigeria	2	2
Ruanda	-	1
Senegal	-	3
Sudan	2	1
Tanzania	1	-
Zaire	1	8
Zambia	1	-
Subtotal	13	21

Table 1 (cont.)

	1973-1974	1984-1988
LATIN AMERICA		
Bolivia	1	1
Brazil	2	3
Colombia	3	4
Ecuador	-	1
Guatemala	6	1
Honduras	-	2
Mexico	4	11
Nicaragua	1	-
Paraguay	-	2
Peru	1	9
Subtotal	18	34
CARIBBEAN		
Barbados	1	1
Dominica	2	-
Dominican Republic	-	2
Grenada	-	1
Haiti	3	2
Jamaica	1	-
St. Kitts-Nevis	1	1
St. Lucia	2	1
St. Vincent	1	-
Intra Country	1	-
Subtotal	12	8
WORLDWIDE	2	0
GRAND TOTAL	78	87

Source: The data for Tables 1 and 2 provided by S&T/POP/R on 2/25/88 and 4/15/88. They came from the A.I.D. database.

Table 2

Comparison of Characteristics of Projects in Previous OR Program (1973-84) with the Current OR Program (1984-1988)

	Percentages of Projects Having Specified Characteristic 1973-1984		1984-1988
A. Type of FP Service:			
Household Distribution	51%	-	16%
Distribution Posts	36%	+	40%
Clinic based	28%	+	55%
Methods Free	40%	-	13%
Methods Sold	27%	+	55%
Mobile Units	6%	=	3%
Referrals	34%	+	40%
Pharmacy	3%	=	6%
Social Marketing	3%	+	12%
Rural	58%	-	38%
Urban	12%	+	66%
No. of Projects	78		86 *

[These Ns apply to panels A, B, D, E, and G. Panels C and F contain data for only 71 sub-projects for 1984-88. The pluses and minues were added as a convenience to the reader and do not refer to statistical tests. The "+" indicates that the current sub-projects are more likely than previous sub-projects to have the particular characteristic, the "-" indicates less likely, and "=" indicates little or no change.]

*There were 87 completed (N=82) or ongoing projects (N=5) but data were available for only 86.

B. FP Methods Offered:			
Pills	67%	-	44%
Condoms	62%	+	72%
Spermicides	35%	+	44%
Female Sterilization	29%	-	22%
IUDs	28%	+	47%
Male Sterilization	15%	+	21%
NFP	13%	-	5%
Norplant(R)	0%	=	1%
C. Other Health Services Included in the Program:			
Oral Rehydration Therapy	23%	-	11%
Immunizations	10%	=	6%
Antihelminthics	9%	=	6%
Vitamin A	3%	=	1%

[Note: The 1984-88 data are on 71 subprojects only.]

D. Research Issues:

Community Based Distribution	49%	-	36%
Distributors	19%	-	14%
Training	15%	-	8%
Promoters	14%	-	8%
Primary Health Care/FP	14%	-	8%
Supervision	12%	-	2%
Clinic Services	10%	+	27%
Management	9%	=	9%
Natural Family Planning	9%	-	0%
Income Generation	5%	=	2%
Young Adults	5%	=	3%
Information/Educ/Communication	5%	+	16%
Incentives	4%	=	2%
Logistics/Supplies	4%	=	1%
Work Place	4%	=	6%
Males	4%	=	5%
Female Sterilization	3%	=	5%
Social Marketing	3%	=	7%
Orals	2%	=	3%
IUDs	1%	+	12%
Vasectomy	1%	+	13%
HMOs	0%	=	1%
Self-sufficiency	0%	+	10%

E. Research Designs:

Quasi-experimental	37%	+	42%
Demonstration project (prospective)	32%	-	17%
Field Study (no control group)	21%	=	24%
Evaluation (retrospective)	9%	-	5%
Diagnostic	6	+	14%

F. Data Collection Approaches:

Endline Sample Surveys	55%	-	46%
Baseline Sample Surveys	53%	-	48%
Service Statistics	53%	+	82%
Service Provider Interviews	24%	+	41%
Administrative/Cost Records	21%	+	44%
Repeated Surveys	19%	-	4%
Patient/Client Interviews	19%	+	37%
Baseline Census	15%	-	3%
Qualitative/Narrative Reports/ Focus Groups	10%	+	38%
Endline Census	9%	-	1%

[Note: The 1984-88 data are for 71 sub-projects only.]

G. Output Measures:

Contraceptive Prevalence	62%	-	26%
New Acceptors	32%	=	33%
Cost-Effectiveness	29%	+	48%
Continuation Rates	18%	=	17%
Active Users	14%	+	20%
Contraceptive Sales	8%	=	12%
Efficiency	4%	+	20%
Fertility Rates	4%	=	2%
Goal/Target Setting	2%	=	2%

Source: A.I.D. Population Projects Database. Numbers provided by Ms. Vicki Ellis, S&T/POP/R, 2/8/88 and by Dr. J. Bailey, 4/15/88.

Table 3

Characteristics of OR Sub-projects (1984-88) by Region

Characteristic	AFRICA	ASIA	LATIN AMERICA/ CARIBBEAN	TOTAL
1 No. of countries having sub-projects	10	6	15	31
No. of sub-projects				
Completed	0	2	3	5
Ongoing	21	22	39	82
TOTAL	21	24	42	87
2. % of sub-projects by issue being studied (alphabetical order)				
CBD	48	43	26	36
Clinic services	24	39	21	27
Distributors	33	4	10	14
Female sterilization	5	9	2	5
HMOs	-	-	2	1
IE & C	5	17	21	16
Incentives	-	-	5	2
Income generation	-	9	-	2
IUDs	10	13	12	12
Logistics/supplies	-	-	2	1
Males	5	-	7	5
Management	5	13	10	9
NFP	-	-	-	-
Orals	-	9	2	3
PHC/FP	5	9	10	8
Promoters	5	9	10	8
Self-sufficiency	10	30	-	10
Social Marketing	-	4	12	7
Supervision	10	-	-	2
Training	-	-	17	8
Vasectomy	14	13	12	13
Work place	-	4	10	6
Young adults	-	-	7	3

Characteristic	AFRICA	ASIA	LATIN AMERICA/ CARIBBEAN	TOTAL
3. % of sub-projects by type of study design				
Demonstration	33	4	17	17
Evaluation	-	13	2	5
Field Studies	19	26	26	24
Diagnostic	5	30	10	14
Quasi-experimental	43	43	40	42
4. % of sub-projects by type of output indicator used to measure impact/change				
Active users	10	39	14	20
Continuation rates	29	17	12	17
Contraceptive prev.	38	29	29	31
Contraceptive sales	5	9	14	12
Cost-effectiveness	19	48	62	48
Cost per CYP	-	9	14	12
Efficiency	-	39	19	20
Fertility Rates	5	-	2	2
Goal/Target setting	5	-	2	2
New acceptors	14	52	31	33
5. % of sub-projects by type of FP service delivery program				
Clinic-based	43	61	57	55
Distribution posts	62	13	43	40
Household dist.	5	43	7	16
Methods free	-	35	7	13
Methods sold	52	48	60	55
Mobile units	-	4	5	3
Pharmacy	5	4	7	6
Referrals	38	52	33	40
Rural	43	48	31	38
Urban	52	65	74	66
Social Marketing	5	9	17	12
6. FP Methods Provided				
Condoms	67	74	74	72
Female steriliz.	14	43	14	22
Spermicides	71	13	48	44
Injectables	19	39	10	20
IUD	29	61	48	47
Vasectomy	-	43	19	21
NORPLANT(R)	-	-	2	1
NPF	5	4	5	5
Orals	19	61	67	44

APPENDICES

A. PERSONS INTERVIEWED

B. DOCUMENTS REVIEWED

C. QUESTIONNAIRE

D. SUGGESTIONS FOR IMPROVING THE OR PROGRAM

APPENDIX A

PERSONS INTERVIEWED

APPENDIX A

PERSONS INTERVIEWED

A.I.D. (S&T/POP):

John Dumm
Barbara Kennedy
James Shelton
Jerald Bailey
Marcia Townsend
Sidney Schuler
Carol Dabbs
Harriet Destler (brief discussion)

A.I.D./Bureaus:

Jack Thomas
Gary Merritt
Patricia Gibson
Maria Mamlouk (brief discussion)
Ruth Frischer
Anna Quandt

Universities:

Ronald Freedman
George Simmons
Miriam Labbok

Operations Research Contractors/Cooperating Agencies:

Columbia University:
- Allan Rosenfield
- Martin Gorosh
- Don Lauro
- John Ross
- Maria Wawer

The Population Council:
- George Brown
- Margaret McEvoy
- Francine Coeytaux
- John Townsend
- Sandra Rosenhouse
- Pauline Russell-Brown

University Research Corporation:
- Paul Richardson
- Myrna Seidman

Tulane University:
- Jane Bertrand

Population Officers (Country & Regional)/Population Advisors:

John Burdick (Peru)
Carol Carpenter-Yaman (Indonesia)
Sarah Clark (REDSO-East)
Art Danart (REDSO-West Africa)
Sharon Epstein (Bangladesh)
Edwin McKeithan (Thailand)
Gloria Nictawitz (Peru)
David Oot (Kenya)
Nevil Selman (Barbados)
James Smith (Colombia)
Sam Taylor (Mexico)
Michael White (Haiti)
Holly Wise (Barbados)

Other Population Organizations:

Douglas Huber (AVSC)
Joseph Speidel (Population Crisis Committee)
Catherine Cameron (Population Crisis Committee)
Peter Donaldson (National Academy of Sciences-brief conversation only)
Dierdre Strachan (Pathfinder Fund)

ISTI:

John McWilliam
Betsy Stephens

APPENDIX B

DOCUMENTS REVIEWED

APPENDIX B

DOCUMENTS REVIEWED

(1) Scope of Work: Evaluation of the A.I.D. Family Planning Operations Research Program, January 15, 1988.

(2) Bailey, Jerald, "A.I.D.'s Operations Research Program," paper presented at the January 1987 Cooperating Agencies meeting, Rosslyn, Va.

(3) Project Paper, "Strategies for Improving Service Delivery Project, 936-3030," April, 1984 and Population Sector Council Minutes, January 12, 1984.

(4) McGuire, Elizabeth S., "Family Planning Operations Research: A Decade of Experience," National Council of International Health Proceedings from June, 1985 meeting.

(5) Gallen, Moira E. and Ward Rinehart, "Operations Research: Lessons for Policy and Programs," Population Reports, May-June, 1986.

(6) Mamlouk, Maria E. and Duff G. Gillespie, "The Importance of Control Groups in Testing Health and Family Planning Interventions," Paper prepared for National Council of International Health, 11th Annual International Health Conference, June 11-13, 1984, Arlington, VA.

(7) Ross, John and Regina McNamara, "Guidelines for Operations Research in Family Planning Programs," October 1986. [Background document for Workshop on Guidelines for Operations Research in Family Planning Programs, held in New York City, December, 1986.]; Ross, John, Jose Donayre, and Regional McNamara, "Perspectives on Operations Research," International Family Planning Perspectives, Vol 13, No. 4, December 1987, pp. 128-135.

(8) Report on the Meeting, December 11-12, 1987, Workshop on Guidelines for Operations Research in Family Planning Programs, Center for Population and Family Health, Columbia University, May, 1987.

(9) Williamson, N. "Family Planning Research Needs in Developing Countries," Family Health International, Fall, 1987. Revised ~~January, 1988.~~

Progress Reports:

Asia: "Family Planning Operations Research/Asia Project," September 1, 1986-August 30, 1987, University Research Corporation.

Zaire: 36 Month Progress Report and Workplan for Year IV: October 1987 to September 1988: "Continuation and Expansion of Family

Planning Operations Research in Zaire," prepared by Jane T. Bertrand, Tulane University, Dec. 14, 1987.

Africa: Africa: New Frontier in Family Planning, Lessons Learned from Operations Research. Report from the Operations Research Program. Center for Population and Family Health, Columbia University, January, 198.

Latin America: Progress Report, Private Sector Community-Based Distribution and Commercial Social Marketing Strategies in Colombia, April 1, 1987-September 30, 1987. Submitted by PROFAMILIA and The Population Council (includes 15 Appendices.)

A.I.D. Quarterly Status Reports (Quarter Ending 6/30/87), ST/POP/R.

Summaries of Projects:

PPD summaries of projects under 932-0632 and 936-3030 (OR projects). (Compiled by Johns Hopkins University and John Snow Incorporated. Includes 125+ OR projects.

"Family Planning/Operations Research/Asia Project," University Research Corporation, January, 1988.

"Teaching and Practicing the Ovulation Method in Rural Kenya"

"Family Planning Operations Research in Indonesia: Testing Approaches to Program Sustainability" (covers 5 related projects)

Other:

Correspondence with Congress regarding OR program and measurement of program effectiveness.

Tabulation prepared by ST/POP/R on characteristics of projects in previous and current OR program as of 2/88.

Books:

Osborn, R.W.and W. A. Reinke (eds.), Community Based Distribution of Contraception: A Review of Field Experience, August, 1981, Johns Hopkins Population Center, The Johns Hopkins University, School of Hygiene and Public Health.

Sirageldin, I., D. Salkever and R.W. Osborn (eds.), Evaluating Population Programs: International Experience with Cost-effectiveness Analysis and Cost-benefit Analysis. St. Martin's Press, New York, 1983.

Wawer, M., S. Huffman, D. Cebula, and R. Osborn (eds.), Health and Family Planning in Community-Based Distribution Programs, Westview Special Studies in Social, Political and Economic Development, Boulder and London, 1985.

2R'

APPENDIX C

QUESTIONNAIRE

APPENDIX C

INTRODUCTION TO INTERVIEW

I have been asked to help with the first phase of an evaluation of the A.I.D./S & T/Pop Operations Research program, "Strategies for Improving Service Delivery." The assignment is to examine, describe, and assess the first three years of the OR program under the current project paper and make comparisons with the previous ten years. The emphasis is on a general review of the OR program rather than an evaluation of the specific projects. I have been asked to prepare an agenda for the second phase evaluation. Key personnel inside and outside USAID will be interviewed in person or by phone; the assignment does not involve foreign travel. The report is due by March, 1988.

DRAFT QUESTIONNAIRE

1. What research activities of the OR program are you familiar with?

2. As far as you know, what are the objectives of A.I.D.'s OR program?

3. In the coming 5 years, should OR have more, less or the same emphasis in A.I.D.'s overall program?

4. As far as you know, are there more good projects than can be supported with current funds?

5. As far as you know, are the current OR activities useful in improving FP programs?

Can you give examples?

6. Should A.I.D/ Pop/R support FP evaluation (i.e., applied or programmatic) research? Why? Why not?

7. Should A.I.D./Pop/R support Technical Assistance (TA) to FP programs? How much priority should this have? Should it be long term TA? If so, who should be the advisors? Americans? Locals?

Europeans? Advisors from more developed LDCs? What are the relations between OR and TA? If more TA is recommended, what problems can be anticipated with this? Do the CAs have the capability to provide this assistance? Should there be more emphasis on institution building in general (for example, management assistance)?

8. In your experience, are there ways in which OR subprojects might have possible negative impact on FP services (for example, by diverting the attention of service providers from services toward research)?

9. How could A.I.D.'s OR assistance be more useful (including any suggestions for improvements in the way the program is administered)?

10. The current program has regional (and one country) programs. Do you favor this regional arrangement? What are the advantages and disadvantages of the regional approach? What are the relations between different CA's doing OR?

11. The current program has field offices in a number of countries Should there be more or fewer offices?

12. What do you think are some of the strengths and weaknesses of the current projects and subprojects?

13. What ideas do you have for any new OR activities? (projects,

subprojects, organization, general products)

14. Should there be more emphasis on dissemination of findings? Locally? Internationally?

15. Should local policy makers and program managers be more involved in the research?

16. Do you favor more OR projects supportive of AIDS prevention activities?

17. How do you define OR?

18. How much emphasis should be put on quasi-experimental designs? Are there other designs which you feel are particularly appropriate?

19. What areas of research are most needed? Are there important areas that have been neglected? What do you think the priority research areas should be in the future (whether worldwide or regional)?

20. Do you favor smaller numbers of large projects, more small projects, or the current mix of large and small subprojects? Have the larger projects had commensurately more impact?

21. How much emphasis should be place on local data processing capability and microcomputer technology transfer?

22. Most appropriate mix of methods: qualitative vs. quantitative; focus groups; process evaluation, case studies, etc.

23. In your view, is the mix of public/private sector projects appropriate?

24. Should management assistance be a part of the OR project? (i.e., assistance for implementing projects and/or for research management)? What are relations between management information systems and OR?

25. Local research can be done by an independent research organization (public or private), by an evaluation unit in a government ministry, by an evaluation unit attached to an MCH or FP program (public or private), etc. In your experince, what are the advantages and disadvantages of working with these different arrangments. Which do you favor?

26. Overall, do you recommend that the A.I.D. OR project be renewed for the next five years (1989-1994)? Why? Why not?

APPENDIX D

SUGGESTIONS FOR IMPROVING THE OR PROGRAM

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Listed below are some of the specific suggestions for improving the OR program made by those interviewed. Other suggestions have been incorporated into the report itself.

Types of FP Programs:

1. OR projects should explore a wider range of potential FP providers (private physicians, mission hospitals, traditional practitioners) before deciding on which groups to work with.

2. If there is a prospect of improving a large government program, a public sector project should be preferred over smaller projects in the private sector. (With the current emphasis on private sector projects, some NGOs may be becoming overloaded.)

3. More thought should be given to the countries selected for OR sub-projects. Will there be an impact on a large population?

Research Design:

1. Before OR field staff prepare research agendas, they should consult closely with service delivery groups, including C.A.s. involved in service delivery.

2. Project proposals should be in the local language as well as in English.

3. There should be more short-term training courses in OR, including for FP managers. Such courses should also cover process evaluation.

4. The OR program should give less emphasis to testing models and setting up special projects outside the existing system (although its original thrust may still be appropriate in Africa where it is still necessary to prove "it can be done").

5. Simpler designs should be encouraged including innovative de-

signs (constructive replication, clustering of projects, meta analysis).

6. Using control groups may not be politically acceptable in some settings because it looks like one group of people are being deprived of something.

Data Collection:

1. Service statistics should be used more extensively to evaluate OR projects with less reliance on special purpose surveys. Modules can be added to other surveys to save costs.

2. We need more process evaluation and more anthropological research (what's really going on? how do people perceive the services?).

3. Some sub-projects should try to monitor impacts on fertility, birth intervals and not just couple years of protection or contraceptive prevalence.

4. Less data should be collected; less costly data collection systems should be used. New editing software may speed things up; data should be processed locally on microcomputers.

5. Very often the people implementing a project are a gold mine of information on why things worked or flopped---if any one takes the time to talk with them.

Research Topics:

1. IEC: what kinds of messages encourage people to choose small families, use contraception, and choose certain methods? (FP programs often use the same tired messages.)

2. Studies could examine the effect of programs on promotion of ~~birth spacing including promotion of breastfeeding; integration~~ of breastfeeding and family planning.

3. Adolescent fertility.

4. In some settings, sub-projects should study FP methods A.I.D.

does not provide (e.g., injectables).

5. More research could be done on the potential contributions of volunteers and how to keep them involved over time.

6. How can countries rise above plateaus in contraceptive prevalence?

7. AIDS including its connections with FP methods; contribution of FP programs to prevention of AIDS; impact on FP programs of AIDS.

8. Impact of social marketing projects; evaluation of the contributions of the commercial sector.

9. Relation of modern and traditional methods and how to promote their use and integration. Is it more effective to introduce FP in traditional societies by building on traditional methods or by ignoring them and introducing modern methods? How would one integrate traditional methods in FP programs?

10. Potential contribution of new methods such as NORPLANT(R) including affordability, replacement effects, impact on prevalence; ways of introducing new methods.

11. Quality of care; intervention projects to increase informed choice.

12. Cost issues; cost recovery. Even in fledgling FP programs, it is not too early to consider costs. Why try an approach that could be affordable in the real world? When costs are recovered, where does the money go? How can it be put into health/nutrition services or other worthwhile causes?

13. Barriers to contraceptive use: pelvic exams, pap smears, lab tests, eligibility requirements, etc.

14. Continuing users; compliance; ways to increase use effectiveness in the general population (as opposed to clinic populations).

15. Most efficient mix of governmental and non-governmental FP services and IEC.

16. Male involvement in health and FP; male methods.

17. In Africa at least, the research mandate could be broadened to include infertility, STDS, AIDS, and other aspects of reproductive health.

18. More research is needed on currently taboos subjects: community incentives, FP services for adolescents; abortion.

Project Implementation:

1, There is a great need for management training to implement projects to improve FP service delivery.

2. T.A. should be an integral part of each OR project and sub-project.

Institution Building:

1. There should be more coordination among different C.A.s regarding local data processing and compatibility of hardware and software.

2. More local staff should be hired (including 3rd country nationals). A.I.D. policies should facilitate this when possible.

3. OR staff should resist doing the job themselves. The task is to teach people how to do things themselves. We are in the development business. The process of doing sub-projects (including getting program managers and providers to focus on service delivery problems) may be as important as the outcome. There should be genuine collaboration.

4. OR contractors should get credit ("brownie points") for giving T.A. T.A. should not just be considered a means to getting sub-projects started and completed but should be considered important in building the capability of local organizations to do OR and improve services.

Management/Cooperating Agencies/Bidding:

1. The current bidding process leads to considerable waste of time as a new organization gets set up. It also leads to competition

between groups of researchers who should be working together. Some contracts might not be bid and A.I.D. could put a longer-term effort into building their capability to do good OR.

2. Having each contractor conduct X number of studies in Y years does not necessarily assure that anything significant will result. There should be less emphasis on number of projects and more on the usefulness and potential impact of the projects.

3. CTOs need more travel money to monitor their projects.

4. It is important to train new people in OR in the U.S. and elsewhere. The C.A. system cuts out universities. Possibly some provision could be made for including universities in OR projects. (For example, there could be room made for unsolicited proposals to C.A.s. from U.S. based organizations.) This interchange would contribute to the training at universities being more relevant and giving field experience to university researchers as well as adding skilled manpower to OR. There were complaints by some respondents that the OR staff working in the field were not sufficiently well trained to do good OR.

5. The OR program should try to minimize the number of rules and regulations. It should try to simplify the project approval process.

6. There should be more field offices, resident advisors, and a regional office in W. Africa.

7. Several respondents suggested that contractors should be able to approve sub-projects under a certain funding limit ($50,000? $100,000?) without having a sub-project approved in Washington.

8. Provision should be made for following up sub-projects several years after they finish---to assess their impact.

9. Technical people, and not just contracts people, should be involved in decisions about overhead charges since if overheads are very high, technical people may want to look consider another bidder.

10. The financial ceilings of projects should be high enough to allow for possible buy-ins.

11. Sub-projects could be concentrated in countries for more im-

pact (e.g., as in Colombia, Zaire, Indonesia) rather than spread them thin: one per country.

12. If OR C.A.s get buy-ins, there should be some provision for increasing staff to do the work of the buy-ins. There could be a ratio (1 staff member for every X amount of buy-in money). Otherwise, there is no one to do the work of the buy-in.

13. A.I.D. might try to improve the quality of the bids for projects by doing a pre-RFP assessment of the capabilities of a handful of potential bidders and give them lead time to improve their capacity to do good OR---assuming this could be done without out jeopardizing rules governing fair competition.

14. A.I.D. should encourage OR projects to hire national staff (to work in their own countries or neighboring countries). One way to do this is to allow salaries that will attract these individuals. In some cases, this may mean waiving the requirement that salaries have to be in line with salaries of local staff employed by the Mission.

General Products:

1. A manual could be prepared on how to do process evaluation (or The Pop Council could expand its earlier manual to include this).

2. State of the art papers could be prepared on sustainability, informed choice, quality of care, and measures of FP performance, drawing from the worldwide experience of OR.

3. A manual on how to analyze focus group data would be useful. [One is under preparation.]

4. Video tapes on how to use OR to manage FP programs and on use of focus groups to understand consumer perspectives could be useful. [Note: These are under development.]

5. A manual on how to use service statistics to manage programs could be useful to many FP programs, including those which have not had the benefit of OR sub-projects.

Dissemination of Results:

1. Money must be provided within study budgets for dissemination of results (including translations, seminars, publications, videos, etc.) It is not sufficient to have a new, separate project which does dissemination. Dissemination of information on a study should go on throughout the life of a project---not just at the end.

2. Very short descriptions of newly developed projects should be prepared and widely disseminated even before any results are available. The one (or 1/2) page summaries being prepared by URC were mentioned by several respondents as a good model.

3. Negative results should also be disseminated since often we learn more from failures than successes.

4. Missions Directors and Deputies should be briefed about OR results in-country. There could also be briefings at regional Pop meetings and summer refresher courses in Washington.

5. More graphics should be used to summarize results.

6. Site visits of program managers to project sites (in their own country or elsewhere) may be a very effective way to encourage research utilization.

7. OR contractors might hire people with specialized skills in communication rather than relying on researchers alone to disseminate findings.

8. For the cost of sending one person to deliver a paper at APHA, a project could hire a photographer to document a project.

9. Advisory committees can sometimes be a means of involving policy makers and getting results disseminated and implemented.